Defense Health Agency, J-7, Continuing Education Program Office

June 2021 CCSS Home Study S02: Epidemic within the Pandemic: Battling Obesity in a COVID-19 Climate

Internet Activity Enduring Material, August 9, 2021 – February 8, 2022, Silver Spring, MD

Continuing Education (CE)/Continuing Medical Education (CME) Information

1. Do you typically engage your Behavior Health Clinics for the Behavior Modification Therapy?

   Dr. Mayer: Yes, the MOVE! program is intended to provide a comprehensive lifestyle intervention (CLI), which, by definition, includes teaching on behavior change in tandem with dietary change and physical activity change, all three pillars of change for weight management in the same program. At the Hunter Holmes McGuire VA our initial MOVE! group education series has sessions taught by a behavioral health psychologist + a dietitian + a kinesiotherapist, so that Veterans get education in all three domains. Our behavioral health team also teaches twice monthly group support classes on various behavioral health topics that pertain to weight management. Currently all of our group classes are taught on either Teams or video-voice conference (VVC) platform due to COVID.

2. Any thoughts on intermittent fasting and any comments on giving dietary advice in those with eating disorders?

   Dr. Mayer: Alternate day fasting and intermittent fasting are both forms of intermittent energy restriction using varied plans for when energy is restricted (by day or in the same day). Current research is limited on this dietary approach. Studies using an alternate day fasting or intermittent fasting methodology yielded the same results, which was that there was no difference in weight loss when compared to an alternate calorie-restriction method.

   References:

Catenacci, V.A., Pan, Z., Ostendorf, D., & et al. (2016). A randomized pilot study comparing zero-calorie alternate-day fasting to daily caloric restriction in adults with obesity. Obesity (Silver Spring), 24(9), 1874-1883. https://doi.org/10.1002/oby.21581

Headland, M.L., Clifton, P.M., & Keogh, J.B. (2018). Effect of intermittent compared to continuous energy restriction on weight loss and weight maintenance after 12 months in healthy overweight or obese adults. International Journal of Obesity, 43(10, 2028-2036. https://doi.org/10.1038/s41366-018-0247-2

Roman, Y.M., Dominguez, M.C., Easow, T.M., Pasupuleti, V., White, C.M., & Hernandez, A.V. (2018). Effects of intermittent versus continuous dieting on weight and body composition in obese and overweight people: A systematic review and meta-analysis of randomized controlled trials. International Journal of Obesity. https://doi.org/10.1038/s41366-018-0204-0

Trepanowski, J.F., Kroeger, C.M., Barnosky, A., & et al. (2018). Effects of alternate-day fasting or daily calorie restriction on body composition, fat distribution, and circulating adipokines: Secondary analysis of a randomized controlled trial. Clinical Nutrition, 37(6 Pt A):1871-1878. https://doi.org/10.1016/j.clnu.2017.11.018

Sundfor, T.M., Svendsen, M., & Tonstad, S. (2018) Effect of intermittent versus continuous energy restriction on weight loss, maintenance and cardiometabolic risk: A randomized 1-year trial. Nutrition, Metabolism, and Cardiovascular Diseases, 28(7), 698-706. http://doi.org/10.1016/j.numecd.2018.03.009

It is appropriate to screen for eating disorders and to then refer to psychology and psychiatry colleagues for further assessment and treatment. Weight loss may not be beneficial in some eating disorders. It is also appropriate to screen for depression as a secondary cause of overweight or obesity.
One five-question screening tool that can be used relatively easily in the clinic (patients could fill out a form as they wait potentially, or ahead of the visit) is the SCOFF questionnaire:
References:

Hill, L.S., Reid, F., Morgan, J.F., & Lacey, J.H. (2010). SCOFF, the development of an eating disorder screening questionnaire. International Journal of Eating Disorders, 43(4), 344-51. https://doi.org/10.1002/eat.2067

Morgan, J.F., Reid, F., & Lacey, J.H. (2000). The SCOFF questionnaire: a new screening tool for eating disorders. Western Journal of Medicine, 172(3), 164–165. https://doi.org/10.1136/ewjm.172.3.164

3. Do you screen for eating disorders as part of your evaluation and what screen do you use?

Dr. Mayer: I do ask all patients that I see in MOVE! if they feel they have an element of emotional eating or if they eat when they are not necessarily hungry. If that two-question ultra-rapid screen is positive I try to assure that they will follow-up in the behavioral health support group classes as well as refer them to our Whole-Health program, which in our VA is run by our mental health team. If, with further questioning, there appears to be a significant mental health concern that is impacting their eating then I will offer to refer them to an outpatient mental health provider. Frequently, Veterans are already being supported by the mental health team at our facility so that I message their providers in mental health to let them know, and also strongly encourage the Veteran to discuss how their mental health may be impacting their eating behavior at their next mental health appointment.
The SCOFF questionnaire, originally developed in the United Kingdom in 1999 by Morgan and colleagues utilizes an acronym (Sick, Control, One Stone, Fat, Food). Answering "yes" to two or more of the following questions indicates a possible case of anorexia nervosa, bulimia nervosa, or other eating disorder:

a. Do you make yourself Sick (induce vomiting) because you feel uncomfortably full?
b. Do you worry you have lost Control over how much you eat?
c. Have you recently lost more than One stone [approximately fifteen pounds] in a 3 month period?
d. Do you believe yourself to be Fat when others say you are too thin?
e. Would you say that Food dominates your life?

4. What is your process when a patient is transferring to another TRICARE Region to another military treatment facility (MTF) or to a region without a local MTF to continue weight loss progress?

   Dr. Mayer: In that case I would attempt to reach out to providers there who might be involved with a weight loss program. Alternatively, there might be an option for community care referral if all other local resources have been exhausted. While active duty, options would include military OneSource and Command Fitness Evaluation Program. In the community, available nationally, is the non-commercial weight loss program called "TOPS" Taking off Pounds Sensibly, it is more affordable than any commercial option and gives good information. https://www.tops.org
   I also want to implore every single prescribing provider to please assure that patients are not being prescribed medications that are causing weight GAIN and that are making it even harder than it already is for their patients: Medications and their Effects on Weight Provider Tool (va.gov)
   https://www.healthquality.va.gov/guidelines/CD/obesity/MedsEffectsWeightProviderToolFINAL50817Dec2020.pdf

5. What are your thoughts on Keto diets and other fads like eating for specific body types? Patients often ask about these.

   Dr. Mayer: Good question. From our review of the literature for the 2020 Clinical Practice Guideline update "Management of Adult Overweight and Obesity (OBE) (2020) - VA/DoD Clinical Practice Guidelines" the recommendation is to "offer patients a dietary approach that contributes to a negative energy balance." I agree that there are many different dietary plans that can achieve a negative energy balance. Here is a meta-analysis of 121 randomized trials with 21, 942 patients, looking at several of the more commonly taught dietary plans: low carbohydrate (eg, Atkins, Zone), low fat (e.g., Ornish), and moderate macronutrient (e.g., DASH, Mediterranean) diets. All of these can achieve weight loss. The authors conclusion is that "Differences between diets were typically small to trivial and often based on low certainty evidence."
   Reference:

Johnston, B.C., Kanters, S., Bandayrel, K., & et al. (2014). Comparison of weight loss among named diet programs in overweight and obese adults: A meta-analysis. Journal of American Medical Association, 312(9), 923-933.

   There is no one single "best diet". The literature simply does NOT support that. I think that the dietary plan that the patient can most adhere to long term is the right dietary plan for that patient.

   Certainly, a low carbohydrate ketogenic diet can be successful for a patient, and at 6 months can be more effective for weight loss compared to a low fat diet, however at 12 months there

was no longer any significant difference in weight loss achieved between the two dietary plans: low carb vs. low fat. Both can be successful for a patient. Adherence long term is the key to success. I would add the caveat however that with a true ketogenic low carbohydrate induction phase (<20g CHO/day) close monitoring with a prescribing provider familiar with teaching low carbohydrate diets is needed if the patient is on medication for either blood pressure or diabetes management since those medications will need to be adjusted, sometimes frequently. Also, more interactions with dietitians to work through cravings and slow and careful re-introduction of carbohydrate intake will be needed.

Patients undergoing bariatric surgery will need close dietary follow-up and typically require low carbohydrate diets to minimizes risk of NIPHS (non-insulinoma pancreatiogenous hypoglycemia syndrome) due to resultant change in gut anatomy and potential to develop mismatch in food transit with insulin release over time if high carbohydrate loads are ingested.

Again, the diet that the patient can best adhere to long-term is the best diet for that patient. Taking into account household needs if others are living in the household and what is available at your particular facility in terms of dietitian support and medical supervision support is also important.

6. How do you motivate patients to not think of medications/surgery as a "quick fix/magic formula"?

   Dr. Mayer: I stress to my patients that both medications and bariatric surgery are additional tools that can be added on to the fundamental scaffold of a comprehensive lifestyle change that includes making changes to the behavior of eating (the “why” do I eat), dietary changes (the “what” do I eat and drink) and physical movement (every step and every minute counts). Also, neither medications for weight loss, nor bariatric surgery have ever been studied or used outside of also engaging in a comprehensive lifestyle change program.
   I would also strongly urge every single prescribing provider to please assure that patients are not being prescribed medications that are causing weight GAIN and that are making it harder for their patients: Medications and their Effects on Weight Provider Tool (va.gov)

7. Do you suspect the PO semaglutide going to be approved for weight loss as well?

   Dr. Mayer: I am not aware of any currently submitted new indications but certainly approval for the oral semaglutide (Rybelsus) for and indication for weight loss could potentially be on the horizon based on findings of the Phase 2 trial comparing oral semaglutide to placebo and injection semaglutide 1.0 mg semagutide (Ozempic). Note, this did not compare oral semaglutide to newly (6/4/2021) approved higher dose injection weekly semagluide (Wegovy). However, given that injection semaglutide has shown additional non-inferiority cardiovascular benefit (SUSTAIN 6) whereas oral semaglutide failed to show statistical significance for the primary CV outcome (PIONEER 6) and further, while not head to head, higher dose injection 2.4mg weekly semaglutide Wegovy appears to achieve higher weight loss effects, so that perhaps this is not a current top priority for NovoNordisk?
   References:

Davies, M., Pieber, T.R., Hartoft-Nielsen, M., Hansen, O.K.H., Jabbour, S., Rosenstock, J. (2017). Effect of Oral Semaglutide Compared With Placebo and Subcutaneous Semaglutide on Glycemic Control in Patients With Type 2 Diabetes: A Randomized

Clinical Trial. Journal of American Medical Association, 318(15), 1460–1470. https://doi.org/10.1001/jama.2017.14752

Marso, S.P., Bain, S.C., Consoli, A., & et. al. (2016). Semaglutide and cardiovascular outcomes in patients with type 2 diabetes. New England Journal of Medicine, 375, 1834-44.

Husain, M., Birkenfeld, A.L., Donsmark, M., & et al. (2019). Oral semaglutide and cardiovascular outcomes in patients with type 2 diabetes. New England Journal of Medicine, 381, 841-51

8. Is Liraglutide approved by the Food and Drug Administration (FDA) to be used by Type 1 diabetics?

   Dr. Mayer: No. There are no glucagon-like 1 peptide agonists and no sodium glucose cotransport type 2 inhibitors that are approved for use in type 1 (autoimmune) or any type of insulin-dependent diabetes (such as from repeated pancreatitis or partial pancreatectomy) in the United states to date. Safety concerns over increased risk of diabetic ketoacidosis events have either prompted the pharmaceutical company to withdraw from further pursuing approval for these agents in type 1 Diabetes Mellitus (DM) in the United States, or the request has not been approved for use by the FDA.

9. Could Contrave be appropriate for those with depression since it uses Buproprion which is sometimes used for that?

   Dr. Mayer: Yes. It is appropriate when choosing a medication for weight loss to try to tailor the choice to patient specific characteristics. Making sure first to screen for any possible contraindications for use, and then to look for additional secondary benefits that could be helpful to the individual patient. For example, if a patient is also an active smoker then Contrave (bupropion + naltrexone) may be an excellent choice, if no contraindications for use. If a patient is struggling with migraine headaches, neuropathy or insomnia, then off-label topiramate monotherapy at bedtime could be trialed, could also consider Qsymia (topiramate + phentermine) if there is a history of migraine headache or neuropathy.